CALIGRA MANAGEMENT, LLC
1201 ELKFORD LANE
JUSTIN, TX 76247
817-726-3015 (phone)
888-501-0299 (fax)

Notice of Independent Review Decision

April 28, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Injection diagnostic, therapeutic substance lumbar, fluoroscopic guidance and localizing NDL/CATH SPI diagnostic/therapeutic

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Pain Management Physician

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:
The patient is a female who was injured at work after sustaining a fall. She fell forward on a ramp landing on her knees, both arms and back.

2014: On June 6, 2014, evaluated the patient for complaints of knees, back and wrist. The symptoms were moderate and occurring constantly. They were aggravated by walking and relieved by nothing. She reported overall soreness. She was utilizing progesterone micronized, hydrochlorothiazide, omeprazole, EstroGel pump and Flexeril. She rated the pain at 7/10. Examination revealed tenderness in arm and forearm. The gait was antalgic. There was lumbar tenderness. The lumbar range of motion (ROM) showed moderate pain with motion. There was left elbow tenderness with mild pain on ROM. There was pain on left hip ROM. Left knee showed tenderness and abrasions. diagnosed the patient with multiple contusions, lumbar strain and knee abrasions. The patient

was prescribed over-the-counter (OTC) Tylenol and recommended pain management.

On June 11, 2014, , FNP, evaluated the patient for ongoing moderate to severe pain in knees, back and wrist. The symptoms were associated with decreased mobility and spasms. The patient rated the pain at 8/10. diagnosed abrasions to lower extremities, contusion of lower limb at multiple sites, lumbar sprain/strain and status-post fall. The patient was prescribed Flexeril and heating pad. She was also recommended continuing OTC Tylenol, stretches and ROM exercise.

On June 18, 2014, noted the patient continued with ongoing symptoms. She had nocturnal pain, myalgias, moderate pain and spasm. The patient rated the pain at 8/10. The patient was referred to orthopedics for evaluation and treatment regarding the lumbar sprain/strain.

On June 20, 2014, evaluated the patient for lumbar spine pain, left elbow pain and bilateral knee pain. Examination revealed pain in the region of the lower lumbar spine with some decreased ROM. There was pain in the elbow joint line. There were contusions on both knees and pain in both knees with decreased ROM. diagnosed sprain of lumbar spine, contusion and sprain of left elbow and contusion and sprain of both knees. The patient was prescribed Medrol Dosepak and Voltaren cream. She was recommended physical therapy (PT) to lumbar spine, right elbow and both knees. A note for work for four hours a day till June 30, 2014, and then going back to regular work was provided.

From June 24, 2014, through July 25, 2014, the patient underwent 8/10 sessions of PT at Total Therapy Solutions with modalities to include therapeutic exercise, therapeutic activities and neuromuscular re-education.

On June 27, 2014, noted the patient had pain mainly in the region of the back and left sacroiliac (SI) joint. recommended to inject the SI joint on the left and provided a note for 4 hours of work only.

On July 11, 2014, noted the patient had started PT and got little worse due to extra exercises. The patient was prescribed Medrol Dosepak.

On July 25, 2014, the patient received sacroiliac joint injection (Toradol and dexamethasone). The patient had aggravated from the therapeutic exercises. recommended magnetic resonance imaging (MRI) of the lumbar spine and prescribed Valium and Voltaren cream.

On August 6, 2014, MRI of the lumbar spine revealed at L1-L2, L2-L3 and L3-L4, there was no significant disc herniation, canal or neural foraminal narrowing. At L4-L5, there was minimal, less than 1 mm broad-based disc herniation without canal or neural foraminal narrowing. At L5-S1, there was 1 to 2 mm broad-based disc herniation along with mild facet arthropathy. There was very mild canal narrowing. There was mild-to-moderate right and mild left neural foraminal narrowing.

On August 8, 2014, noted the patient was doing little better. Examination revealed pain in the right SI joint. The patient recommended TENS unit in addition to exercises. He also ordered lumbar ESI. A note to work for six hours per day was provided.

On August 20, 2014, the patient complained of severe pain in the left elbow and was hardly able to touch. diagnosed lumbar spondylosis and severe tennis elbow left side. He recommended Decadron and local anesthetic injection to the left tennis elbow.

On September 16, 2014, performed lumbar epidural steroid injection at L5-S1 under fluoroscopy.

On September 19, 2014, noted the patient felt a little better, but not completely better. She was working six hours a day. Examination revealed little discomfort in the left elbow region. sent her to work eight hours a day and prescribed Ambien.

On October 17, 2014, noted the patient's tennis elbow problem was severe. He diagnosed her with contusion of left elbow, knee internal derangement, lumbar sprain and tendinitis of elbow. The patient was recommended to follow-up on a p.r.n. basis.

On November 7, 2014, the patient complained of low back pain and pain in the elbow. She was doing much better and was back at work. Examination revealed minimal pain over left elbow attachment of extensor tendons of lateral epicondyle. There was slight pain in SI joint area, but improved about 80-85%. recommended continuing work and returning in one month's time.

On December 3, 2014, the patient was seen for follow-up for symptoms of low back pain with attempts at flexion of the lumbar spine. On examination, the patient had difficulty doing full forward flexion. The straight leg raise test was slightly decreased on both sides. The patient was diagnosed with contusion of the left elbow, left side knee internal derangement (improved), lumbar pain, lumbar sprain and tendinitis of the left elbow (improved). recommended another lumbar ESI because she had dramatically improved by the first one.

2015: Per utilization review dated January 29, 2015, the request for injection diagnostic, therapeutic substance lumbar, fluoroscopic guidance and localizing NDL/CATH SPI diagnostic/therapeutic was denied with the following rationale: *"The date of injury is listed as June 4, 2014. The request is for a lumbar epidural steroid injection at the L5-S1 level. It is documented that on September 16, 2014, the claimant underwent a lumbar epidural steroid injection. A lumbar MRI obtained on August 6, 2014, revealed findings consistent with the presence of a disc herniation at the L5-S1 level. A medical document dated November 7, 2014, indicated that subjectively, there were symptoms of low back pain. A medical document dated December 3, 2014, indicated that objectively, there were*

symptoms of low back pain with attempts at flexion of the lumbar spine. It is documented that on the date of injury, the claimant sustained a fall in the workplace. For the described medical situation, Official Disability Guidelines would not support this request to be one of medical necessity. This reference would not support this request to be one of medical necessity as specifics are not provided with regard to what type of a response was previously obtained from a lumbar epidural steroid injection. As a result, presently, medical necessity for this request is not established."

Per a letter dated February 9, 2015, stated there was a significant improvement in the symptomatology. However, there was no indication of recent exam showing objective signs of radiculopathy. Another epidural block was ordered.

Per reconsideration review dated March 6, 2015, the appeal for injection diagnostic, therapeutic substance lumbar, fluoroscopic guidance and localizing NDL/CATH SPI diagnostic/therapeutic was denied with the following rationale: *"The patient is a xx-year-old individual who sustained an injury on xx. The patient fell in the workplace. There was a previous adverse determination dated January 29, 2015, whereby the request for lumbar epidural block under fluoroscopy L5-S1 was non-certified. Prior treatment included injections, medications, elbow support and physical therapy (PT). The patient received sacroiliac joint injection on July 25, 2014, and lumbar epidural steroid injection at L5-S1 under fluoroscopy on September 16, 2014, and the patient did well from that, but not completely better. The medications were Ambien 10 mg, Medrol Dosepak and Valium 5 mg. Magnetic resonance imaging (MRI) of the lumbar spine dated August 6, 2014, documented at L1-L2, there was no significant disc herniation, canal or neural foraminal narrowing. At L2-L3, there was no significant disc herniation, canal or neural foraminal narrowing. At L3-L4, there was no significant disc herniation, canal or neural foraminal narrowing. At L4-L5, there was minimal, less than 1 mm broad-based disc herniation without canal or neural foraminal narrowing. At L5-S1, there was 1 to 2 mm broad-based disc herniation along with mild facet arthropathy. There was very mild canal narrowing. There was mild-to-moderate right and mild left neural foraminal narrowing. According to Progress Reports and Notes dated December 3, 2014, the patient was seen for follow-up. On examination, the patient still had difficulty doing full forward flexion. The straight leg raise test was slightly decreased on both sides. Treatment plan was for another lumbar epidural because the patient dramatically improved on the first one. The patient was diagnosed with contusion of the left elbow, left side knee internal derangement (improved) lumbar pain, lumbar sprain and tendinitis of the left elbow (improved). This is a review for the reconsideration for the medical necessity of lumbar epidural block under fluoroscopy L5-51. According to ODG guidelines, radiculopathy (due to herniated nucleus pulposus, but not spinal stenosis) must be documented. There were no objective signs of radiculopathy on exam with reflex, motor or sensory changes or positive straight leg raise. There is no significant nerve root impingement on MRI. There is no objective exam finding consistent with acute radiculopathy. There were several examinations since the epidural steroid injection without specific mention of specific results of the epidural steroid injection. There was a letter from February*

2015 that stated there was a significant improvement. However, there is no indication of recent exam showing objective signs of radiculopathy. Therefore, the request for lumbar epidural block under fluoroscopy L5-S1 is neither medically necessary nor appropriate."

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
No evidence either objective or subjective of improvement which meets ODG criteria after initial ESI. Also, no explanation why catheter would be needed within framework of ODG.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**